HOME HEALTH REQUEST FOR PRIOR AUTHORIZATION

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 15 (Rev. 9/2005)

Clear Fields

Send to:
Medical Services
ND Department of Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544

Part I: RECIPIENT INFORMATION

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Treatment Plan (must be completed) or attach Form 485 Plan of Care		
Frequency of Requested Visits	Total Visits (Units)	
Date Range for Services	Email Address	
Home Health Nurse Signature		Date

Part II: HOME HEALTH AGENCY INFORMATION

Home Health Agency	Agency Medicaid Provider Number	Telephone Number	Fax Number
Address	City	State	Zip Code

Part III: FOR STATE USE ONLY

Reviewed By	Date
Approved - Effective dates of PA From: / / To: / /	Number of Visits
Additional Comments	
Denied (Reasons)	

Criteria for completion of this form:

- To request extended nursing hours
- If services are anticipated to exceed $3,000
- If services are anticipated to last 2 months or longer
- 60 day update review (recommend submitting to Medical Services up to 10 working days prior to update review date)

NOTICE:

The prior approval of this service(s) by the North Dakota Department of Human Services does not guarantee eligibility nor ensure payment for the service(s). Eligibility is established by the appropriate County Social Service Board on a monthly basis and payment is contingent upon the eligibility of an individual at the time of services approved are rendered. Eligibility for dates of service may be verified by calling 1-800-428-4140 or 701-328-2891.

Any applicable third parties must be billed prior to billing Medicaid and third party requirements must be followed. The recipient may be responsible for any recipient liability before payment is made by the department.